



Contents lists available at SciVerse ScienceDirect

Journal of Criminal Justice



Community-based alternatives for justice-involved individuals with severe mental illness: Diversion, problem-solving courts, and reentry

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ARTICLE INFO

Available online xxxx

ABSTRACT

Purpose: Adults with severe mental illness are overrepresented in the criminal justice system, and traditional criminal justice processing has not led to meaningful improvement in recidivism and other relevant outcomes. Fortunately, there has been considerable growth in community-based alternatives to standard prosecution for justice-involved adults with severe mental illness. The purpose of this article is to examine three such community-based alternatives – diversion, problem-solving courts, and reentry into the community – and offer best practice recommendations for developing, implementing, and refining these programs.

Methods: The literature relating to the impetus and rationale for community-based alternatives, an organizing framework for conceptualizing the range of community-based alternatives, and the empirical evidence for community-based alternatives was reviewed.

Results: Existing research on diversion, problem-solving courts, and reentry is generally inconsistent and lacking in uniformity. Although some community-based interventions have a great deal of empirical support, other interventions have received very little research attention.

Conclusions: Research suggests that some community-based alternatives are an effective strategy for adults with severe mental illness, but more empirical research is needed before most community-based interventions can be described as empirically supported.

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Introduction

In recent years, there has been a dramatic shift in how the criminal justice system handles offenders with specific needs, including drug-involved offenders and adults with severe mental illness. As it became clearer that standard criminal justice processing was not resulting in meaningful improvement in terms of relapse to drug use, mental health functioning, and criminal recidivism, the criminal justice system responded by developing an array of alternatives to standard prosecution (Heilbrun et al., 2012). These community-based alternatives span the full criminal justice system continuum and represent a significant departure from how the criminal justice system previously handled offenders with specific needs. Rather than utilizing a one-size-fits-all approach, these interventions target specific risk factors that contribute to criminal behavior, and several community-based interventions have a good deal of empirical support.

In this article, we discuss community-based alternatives to standard prosecution for justice-involved adults with severe mental illness. We focus on three approaches: diversion, problem-solving courts, and reentry into the community. We begin by discussing the impetus and rationale for community-based alternatives, followed by a discussion

of the Sequential Intercept Model (Munetz & Griffin, 2006), which provides a framework for organizing and conceptualizing the range of community-based alternatives. Next, we discuss research related to diversion, problem-solving courts, and community reentry, and we offer “best practice” recommendations for developing/implementing these programs and refining existing programs. Finally, we conclude by offering some recommendations to guide future researchers, with a particular emphasis on “promising practices” and areas in which the research is underdeveloped.

Overview of community-based alternatives

Several factors spurred the development of community-based alternatives to standard prosecution. Perhaps the strongest influence was the recognition that standard criminal justice processing was ineffective in achieving positive outcomes for certain types of offenders. In this regard, the advent of drug courts in the late 1980s was a watershed development. The first drug court was established in 1989 in Dade County, Florida as a local response to the increasing numbers of drug-involved offenders. The local courts recognized that the traditional criminal justice response to such offenders, which was necessarily punitive and often included incarceration, was not achieving meaningful reductions in drug use and criminal recidivism. Drug courts represented a new way of doing business. Rather than simply punishing drug-involved offenders, which had led to a well-documented, costly, and ineffective

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cycle of arrest, incarceration, release, and re-arrest, drug courts sought to address the underlying cause of offenders' behavior by providing a range of treatment, case management, and social services delivered under close judicial supervision (Government Accountability Office, 2011).

The success of drug courts in reducing drug use and criminal recidivism led to the development of other problem-solving courts. Specialty courts that were modeled after drug courts include mental health courts (for offenders with mental health disorders), family dependency treatment courts (for child abuse, neglect, and dependency cases where parental drug use is a contributing factor), veterans' courts (for military veterans with substance use and/or mental health disorders), community courts (for offenders charged with low-level "quality-of-life" offenses), domestic violence courts (for offenders charged with spousal abuse), and prostitute courts (to address the needs of prostitutes and their clients). Problem-solving courts are based on the premise that addressing offenders' underlying needs in a range of areas is the most effective way to prevent further involvement with the criminal justice system. However, as will be discussed, problem-solving courts are only one type of community-based diversion program, and they target offenders who have already penetrated the criminal justice system.

A related justification for community-based alternatives is the nature of treatment that can be provided to offenders in community-based settings, which is often more appropriately targeted to offenders' criminogenic needs. Correctional facilities such as jails and prisons must necessarily prioritize inmate security and public safety ahead of the rehabilitation needs of the inmates. As such, offenders with special treatment needs, such as drug use or mental health problems, may not get the types of targeted services that research has shown to be effective in addressing such needs. By contrast, community-based alternatives can provide targeted interventions to a narrower group of offenders, which presumably increases the likelihood that offenders' treatment needs will be appropriately addressed (Heilbrun et al., 2012).

Despite the relative novelty of many community-based interventions, a growing body of empirical and meta-analytic evidence supports their use. Community-based programs focusing on criminogenic needs are more effective than similar interventions in institutional settings, and programs operating with some independence from justice agencies appear to be more successful (Gendreau, French, & Gionet, 2004). Community-based providers also tend to use more evidence-based practices than institutional providers (Friedmann, Taxman, & Henderson, 2007). Additionally, these interventions appear not to jeopardize – and may even enhance – public safety in the communities where they are implemented (Heilbrun et al., 2012).

Finally, community-based alternatives can be justified by considering the economics of standard prosecution. For offenders with special needs, the costs of incarceration alone or incarceration that involves treatment are staggering when compared to the costs of community-based alternatives. For example, recent estimates suggest that California

is spending \$2 billion each year for prison health care, which amounts to \$11,600 per inmate (Kiai & Strabo, 2010), and much of this cost is attributable to treatment provided to inmates with mental health disorders. By contrast, community-based treatments can offer substantial cost savings over incarceration. Most research suggests that drug courts, for example, produce significant cost savings over traditional criminal justice interventions (e.g., Belenko, Patapis, & French, 2005). Bhati, Roman, and Chalfin (2008) reported that for every \$1.00 invested, drug courts produce \$2.21 in benefits to the criminal justice system, and the rate of return is even higher when drug courts target higher-risk offenders: \$3.36 for every \$1.00 invested. Although earlier research suggested that the net economic benefit to local communities ranged from \$3,000 to \$13,000 per drug court client (Logan et al., 2004), recent research by the Government Accountability Office (2011), which reviewed 11 studies that provided cost-benefit data, found that the net benefit ranged from positive \$47,852 to negative \$7,108 for each drug court client, which suggests that some drug courts were not cost effective.

Sequential intercept model

The Sequential Intercept Model (SIM; Munetz & Griffin, 2006) provides a useful framework for organizing and conceptualizing the range of community-based alternatives to standard prosecution. The SIM describes five points at which the standard criminal justice process of arrest, conviction, and incarceration can be interrupted (or intercepted), which results in a dramatically different procedure for the individual: (1) law enforcement and emergency services; (2) post-arrest: initial detention or initial hearing and pre-trial services; (3) post-initial hearings: jails/prisons, courts, forensic evaluations, and commitments; (4) re-entry from jails, prisons, and forensic hospitalization; and (5) community corrections and community support (Fig. 1).

The first intercept refers to initial contact between the individual and police officers or other first responders. An example of an intervention at this first intercept is crisis intervention teams, which provide police officers with a greater range of options when confronted with individuals with behavioral health disorders, such as drug use or mental health problems. For example, a police officer confronted with an individual who has committed a minor offense, such as disturbing the peace or loitering, may not be aware that options other than arrest are available in his or her jurisdiction. The goals at this first intercept are to keep individuals from penetrating into the criminal justice system, provide treatment instead of arrest for individuals who commit minor offenses due to behavioral health disorders, and reduce the likelihood that police officers will be harmed when they are confronted with individuals with such disorders.

The second intercept focuses on interventions that occur after the offender has been arrested, but before he or she enters a plea or goes to trial. Those at this intercept have obviously penetrated the criminal justice system, but there are several options for jurisdictions that wish

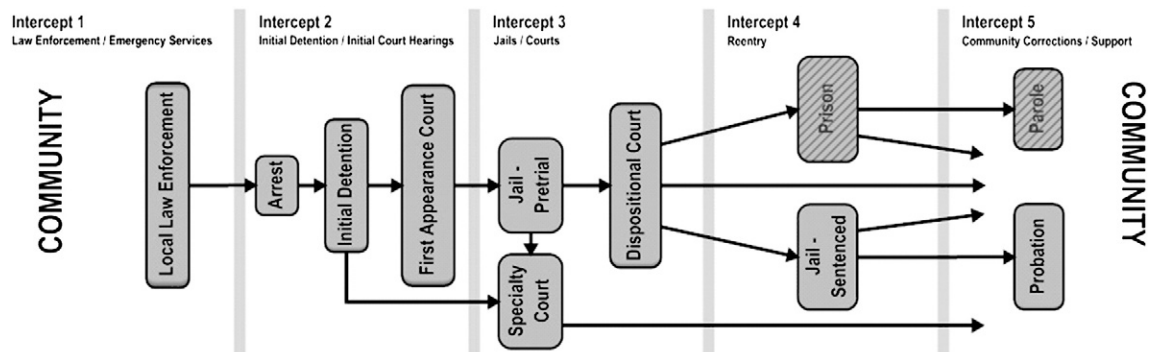


Fig. 1. The sequential intercept model (CMHS National GAINS Center, 2009).

to divert these individuals from standard prosecution and prevent further penetration into the criminal justice system. For example, some jurisdictions offer a specialized form of probation that involves the provision of appropriately targeted interventions that address offenders' needs.

The third intercept occurs after the initial court hearing, and there are a range of community-based alternatives at this stage. Diversion from standard prosecution to problem-solving courts, such as drug courts, mental health courts, or veterans' courts, occurs at intercept three. Problem-solving courts are the most well-researched intervention for offenders with special needs, although some of the newer types of problem-solving courts do not yet have a strong empirical base. However, a well-developed body of research supports the effectiveness of drug courts in reducing drug use and recidivism for drug-involved criminal offenders (see Huddleston & Marlowe, 2011, for a review of relevant research), and a growing body of research provides reason to be optimistic when it comes to the effectiveness of mental health courts (see, e.g., Griffin & DeMatteo, 2009; Redlich, Liu, Steadman, Callahan, & Robbins, 2012).

The fourth and fifth intercepts occur late in the criminal justice process and do not focus on diversion. The fourth intercept focuses on the application of community-based interventions to facilitate successful re-entry into the community following release from incarceration following a conviction, or release from secure forensic hospitalization following an acquittal after a finding of not guilty by reason of insanity. Finally, the fifth intercept describes how community corrections, such as specialized probation or parole, can be used with individuals with severe mental illness.

Diversion

Diversion is a general term that includes all community-based alternatives to standard prosecution that occur before an offender has entered a plea or goes to trial; thus, the offender is "diverted" from standard prosecution and into specialized community-based programming that is better able to address his or her needs. Diversion may occur during the initial contact with law enforcement or emergency service personnel (Intercept 1) or following arrest while the individual is in initial detention, during initial hearings, or while being assisted by pre-trial services (Intercept 2). Specific diversion programs and relevant literature are now reviewed.

Law enforcement and emergency services (Intercept 1)

Law enforcement encounters with individuals with mental illness are common (Borum, Deane, Steadman, & Morrissey, 1998). Diversion at this stage generally involves collaboration between state and local law enforcement, emergency services (e.g., dispatchers and ambulatory services), and community behavioral health treatment providers (e.g., clinical staff from local behavioral health departments, hospital emergency departments, specialized psychiatric centers).

Specialized police and mental health response programs have generally exhibited positive criminal justice and clinical outcomes. One large-scale study found that diverted (vs. non-diverted) individuals spent significantly more time in the community (i.e., out of incarceration or hospitalization), engaged in more counseling sessions, and were more medication compliant (Steadman & Naples, 2005). Prevalence of mental health symptoms was not significantly different for diverted and non-diverted individuals, however, and diverted individuals were more likely to report emergency room visits and hospitalizations at 12-month follow-up. Another study comparing different models of specialized crisis response found wide variability in how these programs operated, but concluded that all were associated with low arrest rates when a specialized response was made (Steadman, Deane, Borum, & Morrissey, 2000).

A widely implemented diversion program is crisis intervention team (CIT) training (Reuland, 2004). CIT training involves training police

officers and dispatchers – typically 40 hours – on the nature of mental illness, availability of community behavioral health services, and crisis intervention techniques (Dupont, Cochran, & Pillsbury, 2007). Emergency dispatchers are trained to recognize calls regarding crisis situations involving individuals with mental illness, and to effectively communicate key details to responding officers. Trained dispatchers will often locate and selectively assign police officers who have completed CIT training to crisis situations involving individuals with mental illness. Following resolution of the crisis, officers take individuals they believe to be appropriate for diversion to a community treatment center in lieu of booking and incarceration. The ultimate goals of CIT training are to decrease response times to crisis situations, provide better care to individuals experiencing psychiatric crises, and increase the safety of police officers who respond to such crises (Dupont et al., 2007). Further programmatic benefits of CIT training include shorter waiting times at emergency rooms for police officers transferring individuals to clinical services, decreased liability for health care issues in jails, and cost savings (International Association of Chiefs of Police [IACP], 2010).

CIT training has generated a large amount of empirical support. Regarding the characteristics of individuals diverted through CIT programs, CIT officers often responded to crises in which individuals with mental illness posed a risk to themselves or others (Skeem & Bibeau, 2008). Further, individuals brought to emergency psychiatric services by CIT officers were similar to non-CIT referred individuals in terms of diagnosis, substance use, disposition, psychiatric presentation, and homelessness; however, CIT-referred individuals were twice as likely to be diagnosed with schizophrenia (Strauss et al., 2005).

CIT officers report feeling better prepared to handle calls involving psychiatric crises (vs. officers utilizing field assistance from a mobile mental health crisis team or in-house social workers; Borum et al., 1998; see also Compton, Bahora, Watson, & Oliva, 2008); are more likely to endorse utilizing lower physical force in crisis situations with psychotic individuals and perceive nonphysical actions as more effective (vs. non-CIT officers; Compton et al., 2011); use physical force conservatively with individuals exhibiting mental illness and risk of violence (Skeem & Bibeau, 2008); and are more likely to divert individuals with mental illness into the mental health system (vs. non-CIT officers; Watson et al., 2010). CIT officers were more likely to direct individuals toward the mental health system if they had prior familiarity with mental illness and a positive view of the availability of mental health resources in their community. CIT training has been associated with an increase in the number and proportion of calls involving possible mental illness, and an increase in the rate of voluntary transport of individuals experiencing a psychiatric crisis to treatment facilities by CIT officers (Teller, Munetz, Gil, & Ritter, 2006). It has also been suggested that CIT training is an effective model to reduce response time to psychiatric crises, reduce costs incurred by specialized police responses (e.g., tactical intervention units), and reduce injury rates for officers (Dupont & Cochran, 2000).

Several challenges have also been noted with CIT training, including misperceptions among CIT officers (e.g., thinking CIT training will solve all problems) and occasional difficulties in collaboration between the justice and behavioral health systems (Dupont & Cochran, 2000). Further, studies have shown that CIT training is inconsistently associated with arrest rates for individuals with mental illness, ranging from a beneficial (Skeem & Bibeau, 2008) to neutral impact (Teller, Munetz, Gil, & Ritter, 2006; Watson et al., 2010). Importantly, it has been suggested that knowledge decreases significantly after the CIT training session, especially among less experienced officers (Compton & Chien, 2008).

Post-arrest (Intercept 2)

When an individual with mental illness is arrested, initial detention and initial hearings afford the opportunity for closer observation and formal assessment to assist in diversion decision-making. Diversion at

this stage typically involves personnel involved in the detention of these individuals – typically from state and local law enforcement, the Sheriff's department, and the local jail – and personnel involved in the disposition of these individuals, including the prosecutor's office, public defender's office, probation department, pre-trial services, and district judges. While some empirical literature exists, post-arrest diversion programming has generally been underutilized and understudied, possibly due in part to logistical obstacles at this stage (e.g., mandatory sentencing schemes, the speed at which individuals are processed and incarcerated, lack of behavioral health involvement).

Existing post-arrest diversion programs vary in terms of individuals served, services provided, and disposition options available. The State of Connecticut and Hamilton County (Cincinnati, OH), for example, have enacted programs including mental health screening, follow-up assessment, court advocacy, and options for pretrial release or deferred prosecution (Clark, 2004). Another program – the Nathaniel Project in New York City – provides court advocacy, pre-release planning, and post-release case management and supervision for individuals indicted for felony offenses and has exhibited good retention at 6 months and 2 years, high levels of treatment engagement, improved housing status, and decreased arrests (National GAINS Center, 2002).

Diversion at this stage has generally been associated with improved criminal justice outcomes, including fewer arrests (Shafer, Arthur, & Franczak, 2004) and fewer days incarcerated (Broner et al., 2004; Broner, Mayrl, & Landsberg, 2005; Steadman & Naples, 2005). Interestingly, post-arrest diversion may reduce jail time only for those arrested for more serious offenses (Hoff, Baranosky, Buchanan, Zonana, & Rosenheck, 1999). While participation has also been associated with improved clinical outcomes, including access to benefits, usage of psychiatric services, and clinical functioning (see Heilbrun et al., 2012), other studies have suggested that post-arrest diversion programs are associated with either inconsistent or neutral changes in criminal justice (i.e., revocation of conditional release; Bertman-Pate et al., 2004) or clinical outcomes (Broner et al., 2004, 2005; Steadman & Naples, 2005).

Recommendations

Specialized law enforcement responding and post-arrest diversion are valuable opportunities to identify individuals with mental illness who are eligible for diversion from standard prosecution at the broadest level. More research is needed on the effects of diversion programming based on initial law enforcement contact, particularly given the mixed results regarding arrest rates and recidivism (see IACP, 2010, for options and recommendations regarding specialized police response). Evaluating obstacles and developing viable solutions will enable such programs to be broadly and effectively implemented, particularly for such issues as misperceptions among police officers regarding the nature and outcomes of the training, diffusion of officer knowledge following the end of training, scheduling difficulties in releasing active duty officers for the full 40 hours of training (especially in rural communities), and friction between law enforcement and treatment personnel related to the amount of time it takes to transfer a diverted individual from police custody into treatment facilities.

Post-arrest diversion programming deserves increased empirical investigation, including both program development and evaluation. Strategies should be developed that capitalize on the standardized and predictable nature of initial detention and initial hearings to better screen for and identify individuals with mental illness who are eligible for diversion. Program developers should work with the court system and policymakers to include diversion alternatives within mandated sentencing schemes. They should collaborate with community behavioral health treatment providers, district attorneys, public defenders, and probation/parole to ensure that diversion programming exists in the community, and that formal procedures are in place to give diverted

individuals the opportunity to participate. Diversion programming developed with collaboration from criminal justice and behavioral health researchers will help to ensure the programs are evidence based, and enable formal evaluation of the programs' cost effectiveness and impact on clinical and criminal justice outcomes.

Problem-solving courts

Problem-solving courts are a common intervention at the third intercept of the SIM. These courts are distinguished from traditional criminal courts by several characteristics: (1) a separate docket for defendants with a specific problem; (2) a dedicated judge who presides over the initial hearing and subsequent status hearings; (3) dedicated prosecution and defense counsel; (4) a less adversarial approach, in which decisions are made collaboratively among the judge, counsel, and relevant professionals; (5) voluntary participation by defendants who agree to follow some form of treatment regimen; (6) intensive judicial monitoring of defendants; and (7) the promise of dismissal or reduction of charges or sentence if the defendant complies with treatment (Moore & Hiday, 2006). Problem-solving courts are based on a theory of "therapeutic jurisprudence," in which the court is an active agent in the defendant's treatment.

The first problem-solving courts were developed in the late 1980s to address the needs of drug offenders, who represented a substantial portion of the incarcerated population but typically did not receive adequate treatment (Belenko, 2001). When studies showed that drug courts effectively reduced drug use and recidivism (Belenko, 2001), the drug court model was adapted for other populations with specific needs (Heilbrun et al., 2012).

Defendants with mental health disorders are obvious targets for problem-solving courts. Persons with mental illness are overrepresented in the incarcerated population and serve longer prison terms than non-mentally ill offenders (McNeil, Binder, & Robinson, 2005). The paucity of treatment resources means it is not uncommon for persons with mental illness to become caught in a loop: they are arrested, sentenced to a jail term during which they receive inadequate mental health treatment, released into the community with no resources to support them, and subsequently rearrested (Schneider, 2010). To break this "revolving-door" cycle, the first mental health court (MHC) program was formed in 1997 in Broward County, Florida. Today, there are more than 200 MHCs, including at least one in a federal jurisdiction (Hiday & Ray, 2010).

While all MHCs deal with similar issues, there are numerous and significant differences in approach among jurisdictions (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006). Some MHCs only accept defendants whose index offenses are misdemeanors, while others also accept felony defendants. There is no uniform standard as to which mental illnesses make a defendant eligible to participate; many courts use broad criteria (e.g., "has an Axis I diagnosis") while others exclude defendants with personality disorders or substance use disorders. MHCs admit participants at different points in the adjudicative process and take different approaches to how and when the index charges are resolved. Courts also differ in how they motivate and sanction participants' compliance or noncompliance (Redlich, Steadman, Petrila, Monahan, & Griffin, 2005). Some courts readily use incarceration as a sanction for noncompliance while others do so only rarely. While all MHC defendants may opt out of the program and have their cases heard in traditional criminal court, only some MHCs allow defendants who exercise this option to return to the MHC after conviction. Finally, some courts offer dismissal of the index charges for those who complete the program, while others offer reductions to less severe charges or sentences.

A growing body of research provides reason to be optimistic about MHCs (see Heilbrun et al., 2012). Several studies have found that participation in MHC results in fewer subsequent arrests for participants compared to their arrest record before participation (e.g., Case, Steadman,

Dupuis, & Morris, 2009). Additionally, MHC participants have fewer subsequent arrests, lower subsequent arrest rates, less serious subsequent offenses, and longer time to reoffense than comparable traditional criminal court defendants (Case et al., 2009; Hiday & Ray, 2010; Moore & Hiday, 2006). Further, MHC participation connects defendants to community mental health resources and is associated with reduced mental health symptoms and improved quality of life (Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2003). Decreases in number of days spent in jail have also been observed compared to traditional criminal court defendants (Case et al., 2009). Thus, MHCs appear to be effective in decreasing subsequent involvement in the criminal justice system. Relatively little is known, however, about how the variations in MHC procedures, sanctions, and criteria for participation are associated with criminal justice and clinical outcomes.

One challenge MHCs commonly encounter is competence to proceed in the criminal process. Defendants referred to MHC vary in their level of understanding and ability to meaningfully participate in the proceedings. This is particularly important in post-plea or post-adjudication MHC models, where the defendant is presumed to understand and consent to the conditions of participation. MHCs must address concerns about competency early and thoroughly. Also, defendants may gain or lose competency while in the MHC. The judge, counsel, and mental health professionals should be attentive to these changes and prepared to revisit the competency determination. As such, MHC personnel should be familiar with the features of common diagnoses seen in MHCs and how they might affect competency.

Defense counsel must be sensitive to how the client's interests are represented in MHC. The collaborative nature of MHC can raise due process concerns, particularly as they relate to adequacy of representation. When defense counsel is acting as part of a cooperative decision-making team, his or her role as zealous advocate for the client is de-emphasized. To avert concerns about the adequacy of representation, defense counsel must attend carefully to the participant's wishes and guard against substituting her judgment for that of the participant.

MHCs must also be cautious in using incarceration as a sanction for noncompliance. While incarceration may be appropriate for a typical criminal defendant who violates supervisory conditions, MHC participants may warrant a different response. Incarceration may interrupt whatever treatment the participant is receiving, and being incarcerated may exacerbate mental health symptoms. MHCs can and should retain incarceration as a tool to respond to noncompliance, but it should be applied only after consideration of the individual case and how it will help (or harm) the participant's recovery.

Recommendations

Given the high rates of co-occurring mental health and substance use disorders among those involved in the criminal justice system (see, e.g., Abram & Teplin, 1991; Teplin, 1994), it is not surprising that a sizeable portion of mental health court clients are dually diagnosed (Council of State Governments, 2008). As such, mental health courts should include an active substance use treatment component to target this criminogenic need. Moreover, increased communication and collaboration between drug court and mental health court personnel, who often treat offenders with similar treatment needs, might prove effective in addressing the criminogenic needs of both populations.

MHCs must develop and maintain connections to a range of community providers. Participants in MHC programs have differing service needs and levels of functioning, so MHCs should have a network of providers of services of varying kinds and intensity. Ideally, the MHC could refer to outpatient providers, assertive community treatment programs (see below), residential programs, and inpatient programs. For veterans participating in MHCs, the VA may be the primary source of mental health services. The more connections the court has among community treatment providers, the more flexible it can be in its response to the needs of participants. Finally, the MHC must ensure that its interventions

target participants' criminogenic needs in addition to their mental health needs. While persons with mental illness face a unique set of challenges, they may also offend for the same reasons as others. MHC interventions that target only the participant's mental health needs may be less effective than those that target those factors known to affect recidivism among the general population.

Reentry

Reentry is a general term that includes all institutional and community-based programming dedicated to assisting individuals with mental illness to re-integrate into the community following release from incarceration or hospitalization, including efforts to prevent further criminal justice system involvement. Though programming may occur shortly before or after release from institutionalization (Intercept 4) or within the context of community corrections and involvement from community partners (Intercept 5), it is important to keep in mind that there is considerable temporal and programmatic overlap between these reentry services (see, e.g., Lamberti, Deem, Weisman, & LaDuke, 2011). Specific reentry programs and relevant literature are now reviewed.

Reentry (Intercept 4)

Formal reentry occurs upon release from jails, prisons, or forensic hospitals and often includes collaborative efforts among the institutions, community behavioral health systems, probation/parole departments, and community-based partners. Though highly community-specific and therefore widely varied, reentry programming can be broadly grouped into programs derived either from assertive community treatment or from intensive case management, and to a lesser extent correctional reentry programs (Heilbrun et al., 2012).

Assertive community treatment (ACT) provides intensive behavioral health services to those with severe mental illness through a collaborative team of psychiatric and substance use treatment professionals, mobile service delivery, time unlimited services, 24 hour crisis availability, and low staff and psychiatrist to client ratios (Dixon, 2000). Given the high rates of arrest and incarceration for those with mental illness, a variety of programs have been developed that apply the ACT model to individuals with mental illness involved in the justice system (commonly referred to as forensic assertive community treatment, or FACT; Lamberti et al., 2011; Lamberti, Weisman, & Faden, 2004).

Participation in FACT is associated with positive short- and long-term criminal justice outcomes – including reduced re-arrests, convictions, and jail days (see, e.g., California Board of Corrections, 2005; Cosden et al., 2003; Lamberti et al., 2001; Smith, Jennings, & Cimino, 2010) – as well as improved clinical outcomes, such as substance use, hospitalizations, and psychiatric functioning (see Heilbrun et al., 2012). Importantly, improved criminal justice and clinical outcomes are significantly associated with greater fidelity to the ACT model (California Board of Corrections, 2005). These positive outcomes have also been shown to lead to cost savings: participation in the Thresholds, State, County Collaborative Jail Linkage Project (2001), for example, was associated with substantial reductions in jail days (2,741 jail days in year before participation vs. 469 after 1 year of participation) and psychiatric hospitalization days (2,153 vs. 321, respectively) that resulted in \$157,000 in estimated annual jail savings and \$917,000 in hospital savings.

Conversely, some studies suggest that FACT does not significantly impact clinical outcomes and may have a neutral (California Board of Corrections, 2005) or even negative effect on arrests, convictions for probation violations, and reincarceration (Cosden et al., 2003; Solomon & Draine, 1995). Importantly, it has been found that the variables associated with arrest while in FACT programming were similar to those found in the general population (i.e., history of arrests for violent offenses before treatment, evictions from residential

treatment, antisocial traits; Erickson et al., 2009), which suggests that these negative criminal justice outcomes may relate more to the inclusion of high-risk individuals in the FACT programs than to the programming itself.

Another community treatment model applied to justice-involved individuals with mental illness is intensive case management (Mueser, Bond, Drake, & Resnik, 1998). Generally considered less involved than ACT programs, intensive case management programs provide behavioral health treatment that emphasizes small caseloads (typically less than 20 individuals) and a collaborative team of treatment professionals, usually consisting of at least one nurse, social worker, and clinical case manager per client. Participation in intensive case management is associated with similar outcomes as FACT – including reduced violent offending, re-arrest, and jail days, and longer time in the community before criminal justice involvement (Broner et al., 2004; Godley, Finch, Dougan, McDonnell, & McDermeit, 2000; Steadman & Naples, 2005; Ventura, Cassel, Jacoby, & Hzuang, 1998; Wilson, Tien, & Eaves, 1995) – but also neutral or negative impacts on clinical outcomes (see Heilbrun et al., 2012). Further, one randomized study comparing FACT, intensive case management, and treatment as usual found no difference among these programs in terms of a variety of clinical and criminal justice outcomes, including arrest rate (Solomon & Draine, 1995).

Correctional reentry programming is another option for individuals with mental illness who are incarcerated, though this alternative has received much less empirical attention (Heilbrun et al., 2012). One example is the Forensic Transition Team, a collaboration including the Massachusetts Parole Board, Department of Corrections, and the Department of Mental Health that provides screening, referrals, and specialized release planning for individuals with mental illness (Hartwell, 2010). After 3 months in the program, 47% of participants who could be reached were engaged in community service, 21% were hospitalized, and 18% were re-involved with the criminal justice system.

Community corrections and community support (Intercept 5)

Community supervision is the most common form of correctional supervision in the United States (James & Glaze, 2006). Individuals in these programs with mental illness – particularly psychotic illnesses – are given fewer opportunities for early release, are more likely to receive suspension warrants, and more likely to have their supervision revoked without commission of a new offense (see, e.g., Porporino & Motiuk, 1995). To address this disparity, community correctional departments have developed specialized programming to more comprehensively serve these individuals (American Probation and Parole Association, 2003; Council of State Governments [CSG], 2009).

Compared to traditional probation, specialty probation programs include reduced caseloads consisting solely of individuals with mental illness, sustained officer training, active integration of internal and external resources to meet probationers' needs, and an emphasis on collaborative problem solving (vs. punitive) strategies to address treatment noncompliance (Skeem, Emke-Francis, & Eno Loudon, 2006). Further, specialty probation agencies have more monthly contact with clients, case managers, and treatment providers, and are less likely to handle treatment noncompliance through persuasion, court appearances, and filing a violation (Eno Loudon, Skeem, Camp, & Christensen, 2008).

A review of specialty probation and parole programs concluded that they are associated with improved clinical outcomes, including better integration into treatment services and enhanced well-being, and it noted a complex relationship between program participation and criminal justice outcomes (Skeem & Eno Loudon, 2006). Specifically, evidence appears mixed on whether specialty agencies actually reduce participants' risk of reincarceration due to technical violations and arrest for new offenses (see, e.g., Perez, 2009). Certain aspects of specialty community supervision – such as participants' treatment motivation (Solomon, Draine, & Marcus, 2002) and caseload size (Skeem et al., 2006) – have been shown to significantly impact the

likelihood of reincarceration due to violations and new charges, emphasizing the need to keep these programs “special” by incorporating effective clinical interventions and maintaining smaller caseloads.

Community treatment and support services are also frequently involved in correctional in-reach, reentry, and community reintegration programming, although the effectiveness of such services have received little to no empirical investigation. In-reach programming is provided by community behavioral health providers, as well as local and national community and faith-based service providers (e.g., Alcoholics Anonymous, the National Alliance on Mental Illness). Vocational training and housing and benefits assistance are also integral services for individuals with mental illness leaving incarceration.

Recommendations

Reentry programming affords behavioral health and justice departments the opportunity to provide better care for those with mental illness, better help them successfully reintegrate into the community, and better prevent further offenses. These services are highly community-specific and are the result of collaborative efforts among stakeholders from criminal justice (particularly jails and probation departments), behavioral health, and community organizations. More empirical work is needed to understand the criminal justice outcomes of forensically focused treatment models like FACT and intensive case management, which should be aided by efforts currently underway to standardize such practices (Heilbrun et al., 2012). The same is true of probation and parole programs specifically designed for individuals with mental illness, particularly given the increased usage and importance of community supervision by the criminal justice system (see Council of State Governments, 2009, for recommendations). Reentry from state prison and specialty parole programming are currently understudied and therefore represent worthwhile targets for criminal justice and behavioral health researchers.

As specialty reentry and community supervision programs become more widespread and widely studied, efforts should be made to identify and capitalize on those elements that are found to be most salient in improving criminal justice outcomes. This will enable reentry programming to remain effective in terms of its improved clinical and criminal justice outcomes, but also make it more cost effective and therefore feasible to be implemented across a variety of communities. Another way to increase these programs' effectiveness and decrease costs is to further involve community service providers to assist in treatment, vocational training, and access to benefits.

Recommendations for future research

There are different questions on which future research would be useful. Existing research in diversion, problem-solving courts, and reentry is generally inconsistent and lacking in uniformity. This means that some interventions (e.g., drug courts, mental health courts) have been well-researched and enjoy good empirical support. Other interventions (particularly post-arrest diversion programming and reentry programming) have received relatively little research attention. But even existing research is lacking in uniformity: basic variables have not been measured, or have been measured quite differently across studies. This makes it difficult to draw conclusions using results from multiple studies. These issues will be discussed in greater detail in this section.

The Sequential Intercept Model (Munetz & Griffin, 2006) provides a useful conceptual framework for identifying stages of the criminal justice system at which rehabilitation-oriented alternatives can be implemented. The SIM itself is a model, not a specific intervention, and therefore generally not appropriate for empirical research on effectiveness. However, when a specific jurisdiction uses the SIM for planning – using “systems mapping” to identify gaps and opportunities in a collective attempt to revise current policy and practice involving

interventions with justice-involved individuals with behavioral health problems – this can be considered an intervention. Accordingly, systems-level research might investigate the impact of systems-mapping upon outcomes relevant to justice involvement for those with behavioral health problems. Other changes at the jurisdictional level, including legislation or appellate court decisions, could similarly be investigated regarding their impact on such justice-involvement variables.

There are five categories of variables that should be considered relevant to the interventions associated with each intercept of the SIM. These include cost, criminal justice outcome, mental health outcome, service process, and perceptions. Cost involves the invested resources – funding, staff time, equipment, and associated costs – necessary to deliver the particular intervention. It may be relevant which system (criminal justice or mental health) bears which of the costs, so this is a question that should be addressed whenever possible. Standard criminal justice outcomes include re-arrest, reconviction, or reincarceration; sometimes technical violations (of the conditions of parole or probation, for instance) are also included. Mental health outcomes typically include some measure of symptoms experienced, adaptive functioning, time in the community, and hospital days. Service process variables measure the nature of participation in the service that is delivered. If the service involves ongoing meetings, then attendance and participation are appropriate measures. Compliance with prescribed medication would also be relevant in measuring mental health intervention. If the service is different – for example, the single encounter that often characterizes crisis intervention team (CIT) – then service process variables might include contrasting outcomes (e.g., arrest versus referral to treatment) as well as the use of force in this encounter. Finally, the variable involving perceptions addresses the responses of the intervention agents, consumers of services, and families regarding the intervention.

When these variables are measured, and compared with a “treatment as usual” group that does not receive the specialized intervention, the resulting study can provide useful empirical data about the nature and effectiveness of the intervention. Unfortunately, it is somewhat unusual for studies in this area to be designed and implemented in this fashion. We will discuss in greater detail how studies at each intercept might incorporate this information to provide the greatest potential conflict to our empirically-based understanding of the relevant interventions.

Research on Intercept 1 could include various kinds of interventions influenced by specialized police responding, including the targeted training provided by Mental Health First Aid (Jorm, 2012). However, the great majority of the specialized interventions and associated research in this area to date have involved CIT. For the purpose of discussing research on Intercept 1 interventions by police, it is not important which of these particular interventions is studied – but it is obviously valuable to collect relevant data that pertain to each different kind of intervention. The particular service process variables should measure the nature of the encounter (where, how long, how many officers, whether all had received specialized training, whether force was used) and the immediate outcome (arrest, taken to emergency treatment, “other”). Longer-term outcome variables, perhaps measured over a period from 6–24 months, would include the standard cost, criminal justice, and mental health outcome measures noted earlier in this section. The attitudes of police, specialty-trained police, consumers, and family are also relevant. To what extent do officers consider CIT and similar programs to be adding to their skills in dealing with a specialized kind of emergency? To what extent would they prefer to use more standard subdue and secure approaches? How satisfied are consumers with the process and outcome of the encounter, both at the time and after a period of time? To what extent are family members favorably disposed to such approaches, and satisfied with the immediate outcome? These are questions that can be addressed through measuring the “perceptions” domain.

Post-arrest diversion programming has received relatively little research attention, so the first need is simply to increase the number

of empirical studies focusing on this intercept. Such research should specify the criteria for diversion into a given program following arrest. If there are more defendants meeting such criteria than there are available places in the program, then the basis for assignment into the program is important. Among other things, such criteria can help to determine whether non-diverted individuals constitute a meaningful control group – or should rather be considered a non-randomly assigned comparison group. The service variables of interest center on the diversion program itself. The nature, frequency, and duration of the treatment service, the attendance and participation in treatment, and perhaps the particular treatment targets, are all important service variables. Cost, criminal justice outcome, and mental health outcome can be measured comparably to what was described earlier in this section. Perceptions of consumers and families are again important, but additional relevant perceptions are those of judges, defense attorneys and prosecutors, and intervention personnel.

Research on Intercept 3 interventions, particularly problem-solving courts, does have a reasonably good empirical foundation. But even this varies by the nature of the court. Drug courts and mental health courts have been well researched; veterans’ treatment courts have not. Researchers do have the advantage of being able to design studies in light of previous research in this area, however. Service variables of particular relevance include the size of the court’s caseload and the level of the staffing, the nature and characteristics of the interventions to which participants are assigned (see previous paragraph), and the extent to which participants satisfy the conditions associated with the specialty court. Cost, criminal justice outcomes, and mental health outcomes are comparable to what has been described previously – although for some kinds of problem-solving courts, it would be more appropriate to use outcomes that are more directly related to the reasons for court participation to begin with. For instance, drug court participants would be measured in terms of sobriety versus relapse into substance use as a primary clinical outcome variable. The perceptions of participants are important, as are the attitudes of the judge(s), prosecutors, defense attorneys, case managers, forensic peers, and intervention providers.

Existing research on Intercepts 4 and 5 suggests that specialized reentry programs such as FACT and intensive case management enjoy the strongest empirical support for effectiveness, and that specialized parole and probation officers who have lower caseloads and a “firm but fair” approach are better able to work effectively with clients with severe mental illness. Each of these can be considered for research purposes as an intervention, with associated research designed to measure intervention effectiveness in the ways discussed for Intercepts 2 and 3. The perceptions of particular interest include the specialty intervention teams (FACT and intensive case management) as well as the parole officer at the final intercept.

The SIM provides a useful framework for considering what research exists in the area of diversion, and what is needed. A good deal of empirical research remains to be done before most of the interventions associated with the SIM intercepts can be described as enjoying solid empirical support. But the conceptual and empirical advances seen in the last decade have been noteworthy, and suggest that the advances of the next decade in this area will be comparable.

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